Registration Form

Minnesota Center For Psychology, LLC

DX Code ____________

Therapist ____________

Date ____________

Patient Information

Patient Name (Print) ____________ Last Name ____________ First Name ____ Initial ____ Date of Birth ____________

Street Address ____________ Cell/Home Phone ____________

City ____________ State ______ ZIP ______ Work Phone ____________

Soc. Sec. # ____________ Emergency Contact ____________ Emergency Phone ____________

Sex: ☐ Female ☐ Male Age ______ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Employer ____________ Occupation ____________

Referred by ____________ May we acknowledge this referral? ____________

Primary Insurance

Primary Insurance Company ____________ Phone ____________

Ins Claims Address ____________ City ____________ State ______ Zip ______

Policy / Member ID ____________ Group/Account # ____________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ____________ Last name ____________ First Name ____ Initial ____ Date of Birth ____________

Address ____________ City ____________ State ______ Zip ______ Relationship ______

Soc. Sec# ____________ Employer ____________

Secondary Insurance

Secondary Insurance Company ____________ Phone ____________

Ins Claims Address ____________ City ____________ State ______ Zip ______

Policy / Member ID ____________ Group/Account # ____________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ____________ Last name ____________ First Name ____ Initial ____ Date of Birth ____________

Address ____________ City ____________ State ______ Zip ______ Relationship ______

Soc. Sec# ____________ Employer ____________

Responsible Party

(Where should the patient's portion of the bill be sent, if not to the patient?)

Name ____________ Relationship ____________

Address ____________ Phone ____________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

____________ Responsible Party Signature ____________ Relationship ____________ Date

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The law requires us to protect the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to this health information. We are required to follow the terms of the Notice that is currently in effect. This Notice outlines our legal obligations regarding your health information and is effective as of February 2, 2010. We reserve the right to change the terms of this Notice and to make the new terms effective for all health information we possess. If this Notice is changed, we will post the revised Notice on our website and in our office, and we will give you a revised Notice upon request.

How We May Use or Disclose Your Health Information

The law allows us to use or disclose your health information for the following purposes:

1. *For Treatment.* We may use or disclose your health information to provide you with medical treatment or services. For example, a mental health practitioner may review your medical record and release medical information for a consultation or referral. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergency circumstances when it is not possible to get your consent.
2. *For Payment.* We may use and disclose your health information to receive payment for treatment that you receive. For example, we may send a bill to your health insurance company that describes the services we provided to you. We will get your written consent prior to making disclosures for payment purposes.
3. *For Health Care Operations.* We may use and disclose your health information for the operation of our practice. For example, we may share information with our staff or employees for training purposes or to assess the quality of care provided in our practice. We will get your written consent before making disclosures to others outside our practice for health care operations purposes.
4. *Communication with Family and Friends Involved in Your Care or Paying Your Bills.* If you are able to make your own health care decisions, we will ask your permission before sharing medical information about you. If you are unable to make health care decisions, our health care practitioners may disclose relevant information if they believe that doing so is in your best interests.
5. *Appointment Reminders.* We may use your information to send you reminders about future appointments.
6. *Notification.* We may disclose your health information to notify a family member, a personal representative, or other persons responsible for your care about your location or general condition.
7. *Public Health Agencies.* We may use or disclose your health information for public health activities such as assisting public health authorities in preventing or tracking disease. We may be permitted and/or required by law to report neglect, child abuse, or abuse of a vulnerable adult.
8. *Health and Safety.* Your health information may be disclosed to avert a serious threat to health or safety of you or any other person. Any disclosure would be only to someone able to help prevent the threat. Minnesota law imposes a duty to warn on certain mental health care providers if a person has communicated a specific, serious threat of physical violence against a specific person.
9. *Law Enforcement.* We will only release your medical information to law enforcement officials in response to a valid court order, a grand jury subpoena, or warrant, or with your written consent. We may release non-medical information about you to law enforcement if we are asked by law enforcement for the information, or as may be required by law. In addition, we may release non-medical information about you if you are suspected of committing a crime on the practice's premises.
10. *Research.* We may use and disclose your information for research purposes, either with your written authorization or otherwise consistent with applicable law. Minnesota law may require consent before your information can be released to an outside researcher. We will make a good faith effort to obtain your consent or refusal, as required by law, prior to releasing any identifiable information about you to outside researchers.
11. *Health Oversight.* We may disclose your information to a health oversight agency for activities authorized by law, including audits and investigations, in order for the government to monitor health care programs and compliance with laws. Minnesota law requires that patient-identifying information be removed from most disclosures for these purposes, unless you have provided us with written consent.
12. *Lawsuits/Disputes.* If you are involved in a lawsuit or dispute, we may disclose information about you in response to a court order, a grand jury subpoena, a warrant, with your written consent, or as otherwise required by law.
13. *National Security, Intelligence, and Protective Services for the President and Others.* We will release medical information about you to authorized federal officials for intelligence, counter-intelligence, national security

activities, and protective services for the President or other authorized persons or foreign heads of state only as required by law or with your written consent.

14. *Decedents.* Health information may be disclosed to funeral directors, coroners, or medical examiners in the case of certain types of death for the purpose of identifying a deceased person, determining a cause of death or other purpose, in accordance with applicable law.
15. *Workers' Compensation.* Your information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation. Minnesota law permits disclosure of your information to the parties involved in the claim, without specific written consent, if the information is related to a workers' compensation claim.
16. *Business Associates.* We may disclose your information to a business associate to perform functions on our behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
17. *As Required by Law.* We may use and disclose your health information as otherwise required by law.

Other uses and disclosures will be made only with your written authorization, which you may revoke, except to the extent we have already acted upon the authorization. We are required to retain records of care provided to you.

Your Rights Regarding Your Health Information

You have the following rights with respect to your health information. If you would like to exercise any of these rights or if you have questions regarding your rights, please contact:

Privacy Officer
Minnesota Center for Psychology
Phone: (651) 644-4100

1. *You have the right to request that we limit our uses and disclosures of your health information.* Requests must be in writing, and you must tell us what information you wish to limit; whether you want to limit our use, our disclosure, or both; and to whom you want the limits to apply. If you pay out-of-pocket in full for an item or service, then you may request that we not disclose information pertaining solely to such item or service to your health plan for purposes of payment or health care operations. We are required to agree with such a request. However, we are not required to agree to any other request.
2. *You have the right to request that we communicate with you through alternative means or locations.* We will respect any reasonable requests. Requests must be in writing, and you must specify how and where you wish to be contacted. We may require you to provide information about how payment will be handled.
3. *You have the right to review and obtain a copy of your health information.* We may charge you a fee for the cost of providing you with such a copy. Requests must be in writing. If we maintain your health information in an electronic health record, you have the right to receive a copy of your health information in electronic form. You may also direct us to provide such electronic health information directly to an entity or person clearly and specifically designated by you in writing. We may deny your request in limited circumstances, such as if the disclosure will be harmful to your health. In such cases, we may supply the information to a third party who may release the information to you. You may have a denial reviewed by another health care professional chosen by the practice, and we will comply with the outcome of that review.
4. *You have the right to request that we amend your health information.* Requests must be in writing, and we may deny your request if it does not include a reason to support the request. We may also deny a request if you ask us to amend information that: was not created by us; is not part of the medical information kept by us; is not information you would be permitted to inspect and copy; or is already accurate and complete.
5. You have the right to obtain an accounting of disclosures of your health information, except disclosures: for treatment, payment, or health care operations; authorized by you; for national security or intelligence; or to correctional institutions and law enforcement with custody of you. Requests must be in writing and may not go back more than six years. You may receive one free accounting in any 12-month period; we will charge you for additional requests.
6. You have the right to receive a paper copy of this Notice.

Complaints

You may complain to us if you think we have violated your privacy rights. You will not be retaliated against for bringing a complaint. Direct complaints to:

Minnesota Center for Psychology
2324 University Avenue, Suite 120
St. Paul, Minnesota 55114
Phone: (651) 644-4100

You can also file a complaint with the Department of Health and Human Services, Office for Civil Rights.

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

Minnesota Center for Psychology, LLC
Diagnostic Assessment Consent Form

Please read the following carefully and sign below, indicating that you understand and agree to the terms of the Diagnostic Assessment Appointment:

1. I understand that this appointment is for a diagnostic assessment only, to determine which, if any services are appropriate for me at this time. This is not a "Consent for Treatment" agreement. This assessment does not establish a therapeutic relationship with the assessment therapist or any other clinician at MCP.

2. I understand that this appointment may help to determine if a therapeutic relationship will be established between myself and the clinician performing the assessment. If I, or the assessment clinician feel that a therapeutic relationship would not be beneficial, no further relationship between myself and the assessment clinician will be established.

3. I understand that it is possible that the type of therapy that I am seeking may not be recommended for me at this time. The clinician performing the assessment will give recommendations for more appropriate services, as needed. Neither MCP, nor the assessment clinician is responsible for obtaining other services for me if the type of therapy I am seeking is not recommended.

4. I understand that I am responsible for any charges not covered by my insurance (co-payments, co-insurance, deductible, etc.) If I receive a bill for services, payment is expected within 30 days. If I am unable to pay the amount in full by 30 days, I must set up a payment agreement with Paragon Billing, Inc. In the event that there is an unpaid balance or I do not adhere to the payment agreement after 90 days, my account may be sent to collections.

5. I understand that I am expected to arrive at my assessment appointment 15 minutes prior to the appointment time, with all required paperwork complete. I must show proof of insurance at this appointment, and all future appointments at MCP. If I do not follow these guidelines, I may not be able to be seen by the assessment therapist at my scheduled appointment time.

6. I understand that if I need to cancel this assessment appointment, I must do so within 24 hours of the appointment, or I may be charged a $50 fee.

____________________	____________________
Client Name (Printed)	Date
____________________	____________________
Parent/Guardian Signature	Parent/Guardian (Printed)

MINNESOTA CENTER FOR PSYCHOLOGY

Midtown Commons • 2324 University Ave. W. • Suite 120 • St. Paul, MN 55114

Phone: 651.644.4100 • Fax: 651.644.4885

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I, ________________________________, Understand that as part of my healthcare, Minnesota Center for Psychology, LLC creates and maintains a paper record describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services were actually provided
- A tool for routine healthcare operations

I have received a Notice of Privacy Practices that provides a more complete description of information uses and disclosure.

I understand that I may revoke this consent in writing, except to the extent that action has already been taken. I also understand that by my declining the terms of this consent or revoking this consent, this organization my refuse to treat me as permitted by section 164.506 of the Codes of Federal Regulations.

I further understand that Minnesota Center for Psychology, LLC reserves the right to change their Notice of Privacy Policy Practices. Should Minnesota Center for Psychology, LLC change their notice, a revised copy is available in the office and will be posted.

I understand that as part of this organization's treatment, payment, or healthcare operation, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for theses permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

________________________________ ________________________________

Patient Signature Parent or Guardian Signature (if necessary)

________________________________ ________________________________

Date Relationship to Patient

FOR OFFICE USE ONLY:

[ ] Consent received and added to patient's medical records by ____________________ on ______________

[ ] Consent refused by patient and treatment is refused as permitted

[ ] Patient is unable to sign or initial because ________________________________

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AGREEMENT ON SERVICES
WHICH MAY NOT BE COVERED BY INSURANCE

My provider may bill the insurance company as a courtesy to me, and I may subsequently receive notice from the insurance company that all or part of these charges is considered by them to be "uncovered services" (deductibles, co-payments, co-insurance, etc.).

However, I understand and acknowledge in advance that I am seeking these services knowing that they may not be covered. I agree to cover the full cost, less any insurance payment. I know that these or similar services may be covered by my insurance company, or covered at a higher rate, if I use providers within my network. I understand that it is my responsibility to know my insurance plan and that I am responsible for knowing what and how much my insurance carrier will cover.

I agree to notify the clinic immediately if my insurance changes or is terminated. I will also update the clinic immediately regarding any changes of address or telephone number.

I understand that I am expected to attend all scheduled appointments or cancel them with 24-hour notice. If I do not do this, I understand that I may be charged a "no show" or "late cancel" fee (the fee does not apply to MA, Medicare clients).

______________________________	______________________________
Client Name (Printed)	Date
______________________________	______________________________
Parent/Guardian Signature	Parent/Guardian (Printed)

FIREARMS POLICY

I understand that Minnesota Center for Psychology, LLC (MCP) bans guns in these premises. I agree that I will not bring a gun into 2324 University Ave., Suite 120, St. Paul, MN 55114.

______________________________	______________________________
Client Name (Printed)	Date
______________________________	______________________________
Parent/Guardian Signature	Parent/Guardian (Printed)

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

Child/Adolescent CONSENT (A)

I voluntarily give permission to Minnesota Center for Psychology to evaluate, administer diagnostic testing, develop a treatment plan and provide treatment. I understand that the practice of psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of assessment or treatment in this facility.

If you are involved in a divorce or custody litigation, please understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this document, you agree not to call me as a witness in any such litigation. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

If you are a parent or family member of a minor child, please also understand that my role is to provide the highest level of quality healthcare to the patient(s) being seen-this includes the limits of confidentiality. Only in situations where the child's or someone else's imminent harm is concerned (harmful to self, others, or being hurt), will you be directly notified. By signing this, you agree that you understand the limits of confidentiality for your child(ren) or family member.

____
Client name (please print)

______________________________ ____________
Client Signature Date

______________________________ ____________
Parent/Guardian/Legal Representative Signature Date

____
Legal Relationship

05/14

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AGREEMENT FOR COLLABORATIVE SERVICES
WITH YOUR PRIMARY CARE PHYSICIAN

In an effort to provide collaborative services with your Primary Care Provider, we are seeking consent to use and disclose information with your current Primary Care Provider. Please check off one of the following boxes and sign below. If you agree to allow communication, we will provide you with a release of information.

- ☐ I agree to allow communication between my primary care and mental health providers.
- ☐ I do not agree to allow communication between my primary care and mental health providers.
- ☐ I do not have a primary care provider.

____ _______________________
Signature Date

MCP

MINNESOTA
CENTER FOR
PSYCHOLOGY

Minnesota Center for Psychology, LLC
Communicable Disease/Parasitic Infestation Policy

Minnesota Center for Psychology (MCP) does not permit clients to attend individual or group appointments if they are currently experiencing a communicable disease or parasitic infestation. The purpose of this policy is to protect the health and safety of our clients, providers and employees.

If, during the course of treatment at MCP, you are diagnosed with, or suspected of having a communicable disease or parasitic infestation, you must notify your therapist immediately. **Clients will not be permitted to return to the clinic until they can provide proof from a medical professional that you are no longer contagious, or proof that you/your home are free from parasites.**

Communicable diseases include, but are not limited to, measles, mumps, rubella, chicken pox, shingles, influenza, viral hepatitis-A (infectious hepatitis), leprosy, meningitis, Severe Acute Respiratory Syndrome (SARS) and active tuberculosis. MCP may choose to broaden this definition within its best interest and in accordance with information received through the Centers for Disease Control and Prevention (CDC). Parasites include, but are not limited to, head lice, body lice, bed bugs, fleas, ticks and mites (scabies).

By signing this policy, you are attesting that you do not currently have a communicable disease or parasitic infestation. You also agree that if, at any time during the course of your treatment at MCP, you are diagnosed with, or suspected of having a communicable disease or parasitic infestation, you will disclose this information to MCP/your therapist immediately.

______________________________ ______________________________
Client Name (printed) Date

______________________________ ______________________________
Client or Legal Representative Signature Relationship to Client

01/23/12

Please complete the attached release forms for any/all of the providers/contacts listed below:

- Individual Therapist
- Psychiatrist
- Primary Physician
- Case Manager
- Emergency Contact → please do
- Other (i.e. spouse, involved family member, child's social worker, parole officer, etc)

Please see the front desk if you have any questions or if you need more release forms.

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name:	Other names used (if any):
Date of Birth:	Social Security Number (voluntary):
I Authorize: Minnesota Center for Psychology 2324 University Ave W, Suite 120 St. Paul MN 55114	Phone: (651)644-4100 Fax: (651)644-4885

To release information to and receive information from:
Name/Agency:
Agency Address:

Agency phone/fax:

Check One:
- ☐ Primary Physician
- ☐ Psychiatrist
- ☐ Emergency Contact
- ☐ Other ___________

Information which may be released includes (check all that apply):
- ☐ ALL
- ☐ Psychological Tests/Diagnostic Assessments
- ☐ Functional Assessments
- ☐ Treatment/Crisis Plans and Reviews
- ☐ Other ___________
- ☐ Phone Contacts
- ☐ Medication Information
- ☐ Discharge Summaries
- ☐ Contact Records

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT release records regarding: ☐ Mental Health ☐ Chemical Dependency ☐ HIV/AIDS

Dates of information to be released: ☐ **ALL** ☐ Other ___________

This information may be released for the purposes of:
- ☐ **Planning or continuing my care and treatment**
- ☐ Planning or continuing CTSS
- ☐ Other (specify)
- ☐ Determining eligibility for insurance benefits
- ☐ Determining eligibility for Social Security benefits

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices*. You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.
Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.
Date of Expiration (not to exceed one year): ___________

Client Signature:	Date:	Parent or guardian Signature (if applicable):	Date:
Phone Number:		Relationship to client:	
Signature of Witness:	Date:	Reason client is unable to sign:	

A photocopy of this release is as valid as the original

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name:	Other names used (if any):
Date of Birth:	Social Security Number (voluntary):
I Authorize: Minnesota Center for Psychology 2324 University Ave W, Suite 120 St. Paul MN 55114	Phone: (651)644-4100 Fax: (651)644-4885

To release information to and receive information from: Name/Agency: Agency Address: Agency phone/fax:	Check One: ☐ Primary Physician ☐ Psychiatrist ☐ Emergency Contact ☐ Other__________

Information which may be released includes (check all that apply):

☐ ALL	☐ Phone Contacts
☐ Psychological Tests/Diagnostic Assessments	☐ Medication Information
☐ Functional Assessments	☐ Discharge Summaries
☐ Treatment/Crisis Plans and Reviews	☐ Contact Records
☐ Other __________	

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT release records regarding: ☐ Mental Health ☐ Chemical Dependency ☐ HIV/AIDS

Dates of information to be released: ☐ **ALL** ☐ Other __________

This information may be released for the purposes of:

☐ **Planning or continuing my care and treatment**	☐ Determining eligibility for insurance benefits
☐ Planning or continuing CTSS	☐ Determining eligibility for Social Security benefits
☐ Other (specify) __________	

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices.* You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.

Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.

Date of Expiration (not to exceed one year):

Client Signature:	Date:	Parent or guardian Signature (if applicable):	Date:
Phone Number:		Relationship to client:	
Signature of Witness:	Date:	Reason client is unable to sign:	

A photocopy of this release is as valid as the original

MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name:	Other names used (if any):
Date of Birth:	Social Security Number (voluntary):
I Authorize: Minnesota Center for Psychology 2324 University Ave W, Suite 120 St. Paul MN 55114	Phone: (651)644-4100 Fax: (651)644-4885

To release information to and receive information from:
Name/Agency:
Agency Address:

Agency phone/fax:

Check One:
- [ ] Primary Physician
- [ ] Psychiatrist
- [ ] Emergency Contact
- [ ] Other ________

Information which may be released includes (check all that apply):
- [ ] ALL
- [ ] Psychological Tests/Diagnostic Assessments
- [ ] Functional Assessments
- [ ] Treatment/Crisis Plans and Reviews
- [ ] Other ________
- [ ] Phone Contacts
- [ ] Medication Information
- [ ] Discharge Summaries
- [ ] Contact Records

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT release records regarding: [ ] Mental Health [ ] Chemical Dependency [ ] HIV/AIDS

Dates of information to be released: [ ] ALL [ ] Other ________

This information may be released for the purposes of:
- [ ] **Planning or continuing my care and treatment**
- [ ] Planning or continuing CTSS
- [ ] Other (specify)
- [ ] Determining eligibility for insurance benefits
- [ ] Determining eligibility for Social Security benefits

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices.* You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.
Revocation Clauses: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.
Date of Expiration (not to exceed one year):

Client Signature:	Date:	Parent or guardian Signature (if applicable):	Date:
Phone Number:		Relationship to client:	
Signature of Witness:	Date:	Reason client is unable to sign:	

A photocopy of this release is as valid as the original

YOUNG CHILD PARENT REPORT FORM

(To be completed before initial intake)

Minnesota Center for Psychology, LLC
2324 University Ave West, Suite 120 • Saint Paul MN 55114
Phone: 651-644-4100 • Fax: 651-644-4885

Date:	Form Completed By: Relationship to the client:

CLIENT INFORMATION

Child's Last Name	Child's First Name	Child's Middle Name
Street Address	City, State, Zip Code	Child's Date of Birth AGE: ____________

√ appropriate box for address: ☐ house ☐ apartment ☐ residential facility ☐ homeless

Name of Parent/s or Guardian/s:

Home Phone Number	Cellular Phone Number	Alternate Phone Number
OK to leave message? ☐ Yes ☐ No	OK to leave message? ☐ Yes ☐ No	OK to leave message? ☐ Yes ☐ No

Race (√ all that apply):

☐ American Indian/Alaska Native Tribe:____________________

☐ Asian (☐ Chinese ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other_______________)

☐ Black/African American (☐ Ethiopian ☐ Somalian ☐ Other_________________________)

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other ________________________

Ethnicity:

☐ Hispanic/Latino/a

☐ Not Hispanic/Latino/a

Primary Language: ☐ English ☐ Other:	Other Languages Spoken:

Religion:

Cultural considerations for treatment:

REFERRAL INFORMATION:

Who referred you to your appointment today?

REASONS FOR WANTING SERVICES Please ✓ all that apply:			
☐ ADHD	☐ Grief/Loss/Death	☐ Panic Attack	☐ Sleep Problems
☐ Attachment Issues	☐ Health Problems	☐ Parenting Issues	☐ Stress
☐ Alcohol Issues	☐ Hearing Voices	☐ Phobia/s	☐ Suicidal Thoughts
☐ Anger Problems	☐ Help Finding Resources	☐ Physical Abuse	☐ Suicide Attempt/s
☐ Anxiety	☐ HIV/AIDS	☐ Physical Pain	☐ Trauma
☐ Body Image/Weight Issues	☐ Hyperactivity	☐ Psychiatric Hospitalization	**Other:**
☐ Bingeing and/or Overeating	☐ Identity Issues	☐ Purging (Throwing up)	☐
☐ Communication Issues	☐ Inattention	☐ Relationship Concerns	☐
☐ Developmental Delay/s	☐ Learning Problems	☐ Restricting Food	☐
☐ Depression	☐ Legal Problems	☐ Sadness	☐
☐ Disruptive Behavior	☐ Memory Problems	☐ Schizophrenia	☐
☐ Eating Disorder	☐ Mood Swings	☐ Self-Esteem Issues	☐
☐ Drug Issues	☐ Obsessions	☐ Sexual Abuse/Trauma	☐
☐ Fetal Alcohol Syndrome	☐ Out of Home Placement	☐ Sexuality Concerns	☐

Please describe the reasons for seeking therapy for your child at this time:

TYPE OF SERVICES REQUESTED: please ✓ all that apply		
☐ Individual Therapy	☐ Family Therapy	☐ Psychological Testing
☐ Social Skills Therapy Group	☐ Other Group Therapy	☐ **Other:**

CHECK ALL THAT APPLY: My Child...		
☐ Changes moods quickly	☐ Shares toys/possessions easily	☐ Says, " I want to die." "I wish I were dead."
☐ Is unable to slow down	☐ Says, "I hate myself."	☐ Doesn't care about the feelings or rights of others
☐ Cries easily	☐ Has trouble controlling anger	☐ Seems unhappy most of the time
☐ Loses temper too easily	☐ Actively refuses to do what adults tell him/her to do.	
☐ Worries about many things	☐ Avoids social situations, or becomes distressed when required to participate	

PLEASE ANSWER THE FOLLOWING:
Did your child reach developmental milestones within normal limits? If no, please indicate difficult areas.
Does your child have any sensory issues? (clothing, light, sound, texture)
Do you have concerns that your child has been the victim of bullying?
How does your child show anger?
What helps your child calm down?
What are some of your child's favorite things?

CHILD MEDICAL/PSYCHOSOCIAL HISTORY

please ✓ all that apply

☐ Alcohol/Drug Abuse	☐ Exposure to Domestic Abuse/Violence	☐ Inattention	☐ Schizophrenia
☐ Allergies		☐ Learning Problems	☐ School Anxiety
☐ Alzheimer's	☐ Feeding Issues	☐ Legal Problems	☐ School Refusal
☐ Anxiety	☐ Fetal Alcohol Syndrome	☐ Manic/Bipolar Disorder	☐ Sexual Abuse
☐ Autism	☐ Foster Care (past or present)	☐ Mental Retardation	☐ Sleep Issues
☐ Bedwetting/Encopresis		☐ Nightmares	☐ Stomachaches with no apparent medical cause
☐ Blood Clot/Stroke	☐ Headaches with no apparent medical cause	☐ Panic Attacks	
☐ Cancer		☐ Personality Disorder/s	☐ Suicide/Attempt
☐ Depression	☐ Heart Attack/Disease	☐ Physical Abuse	☐ Surgery/ies
☐ Diabetes	☐ HIV/AIDS	☐ Physical Pain	☐ Tuberculosis
☐ Eating Disorder	☐ High Blood Pressure	☐ Psychiatric Hospitalization	☐ OTHER:
☐ Epilepsy/Seizures	☐ Hyperactivity		

PLEASE DESCRIBE ANY ISSUES CHECKED ABOVE:

FAMILY MEDICAL/PSYCHOLOGICAL HISTORY

MOTHER AND MOTHER'S SIDE OF THE FAMILY:			☐ Check here if history is unknown
☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

FATHER AND FATHER'S SIDE OF THE FAMILY:			☐ Check here if history is unknown
☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

SIBLINGS (if applicable): ☐ N/A			☐ Check here if history is unknown
☐ Alcohol/Drug Abuse	☐ Diabetes	☐ High Blood Pressure	☐ Physical Pain
☐ Allergies	☐ Domestic Abuse	☐ Hyperactivity	☐ Physical Abuse
☐ Alzheimer's	☐ Eating Disorder	☐ Inattention	☐ Psychiatric Hospitalization
☐ Anxiety	☐ Epilepsy/Seizures	☐ Learning Problems	☐ Schizophrenia
☐ Autism	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Sexual Abuse
☐ Bedwetting	☐ Foster Care (past or present)	☐ Manic/Bipolar Disorder	☐ Stomachaches
☐ Blood Clot/Stroke	☐ Headaches	☐ Mental Retardation	☐ Suicide/Attempt
☐ Cancer	☐ Heart Attack/Disease	☐ Panic Attacks	☐ Surgery/ies
☐ Depression	☐ HIV/AIDS	☐ Personality Disorder/s	☐ Tuberculosis
☐ **Other:**			

LEGAL HISTORY

Has your child ever been arrested or in trouble with the law?
☐ No ☐ Yes Please explain:

Has the child's mental health treatment been court ordered? ☐ No ☐ Yes
If yes, further documentation may be required

EDUCATIONAL HISTORY

Name of School:	☐ Public ☐Private	Grade:
		Teacher:

Current:				Past Year:			
Attendance	☐good	☐average	☐poor	Attendance	☐good	☐average	☐poor
Quality of work	☐good	☐average	☐poor	Quality of work	☐good	☐average	☐poor
Homework behavior	☐good	☐average	☐poor	Homework behavior	☐good	☐average	☐poor
In school behavior	☐good	☐average	☐poor	In school behavior	☐good	☐average	☐poor
Friendships	☐good	☐average	☐poor	Friendships	☐good	☐average	☐poor

Has your child/adolescent ever:			
Repeated a grade?	☐ No	☐ Yes	Grade:
Received Special Education Services?	☐ No	☐ Yes	When:
Been diagnosed with a learning disability?	☐ No	☐ Yes	When:
Been diagnosed with ADHD?	☐ No	☐ Yes	When:
Had a previous Individualized Education Plan (IEP)?	☐ No	☐ Yes	When:
Does your child/adol. have a current IEP?	☐ No	☐ Yes	

Describe your child's academic strengths and weaknesses:

Motivational Problems:

Behavior Problems:

CHILD/ADOLESCENT CURRENT MEDICATIONS

(list more on separate page if necessary):

Prescribed by:

Current Medication	For What Condition?	Dose	Frequency	Date Started	Side Effects/Comments
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Past Medication	For What Condition?	Past Medication	For What Condition?
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Medication Allergies:

YOUR CHILD'S CURRENT PROVIDER(S) AND PROFESSIONAL(S)

PRIMARY CARE PHYSICIAN	PSYCHIATRIST	CASE MANAGER
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:
PROBATION OFFICER	**CPS WORKER**	**SCHOOL COUNSELOR/SW**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:
OTHER	**OTHER**	**OTHER**
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
Length of time services received:	Length of time services received:	Length of time services received:

*PLEASE PROVIDE SIGNED RELEASE FORMS FOR ALL PROFESSIONALS LISTED ABOVE

PAST PROVIDERS AND PROFESSIONALS
(Include Psychologists, Psychiatrists, Social Workers, etc)

TYPE OF PROVIDER:	TYPE OF PROVIDER:	TYPE OF PROVIDER:
Name	Name	Name
Agency/Address	Agency/Address	Agency/Address
Phone	Phone	Phone
Fax	Fax	Fax
When services were received:	When services were received:	When services were received:

I certify that I have answered these questions to the best of my knowledge.

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Parent/Guardian Signature **Date**

CLINICIAN NOTES (clarifications, follow up, etc.)

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____ ____________________

Clinician **Date**

____ ____________________

Cosignatory **Date**